SUBMISSION OF THE OFFICE OF THE CHILD ADVOCATE, IN SUMMARY OF OCA'S REPORT ON THE DEATHS OF INFANTS AND TODDLERS IN CONNECTICUT IN 2013

The Office of the Child Advocate is honored to present information to the Children's Committee regarding the sudden and unexpected deaths of very young children in the state during the last year. We offer the following as a brief summary of prefatory information, key findings and recommendations from this child death review report.

As a preliminary matter, OCA wants to thank the following people for their contribution to this report: Joan Kaufman, Ph.D., Karen Snyder, M.A., all of the members of the Child Fatality Review Panel, Ankeeta Shukla from Yale School of Public Health, and Felicia McGinniss from University of Connecticut School of Law. Many individuals contributed to the development of this report and their expertise and insight were invaluable and much appreciated.

INTRODUCTION

On July 31, 2013, The Office of the Child Advocate released a report analyzing the unexplained and unexpected deaths of infants and toddlers in Connecticut in 2013. The report was issued pursuant to OCA's obligation to review, investigate, and report regarding the efficacy of child-serving systems and develop recommendations for change. These duties also include investigating and reporting regarding the deaths of children involved with state-funded services.

INFANTS AND TODDLERS ARE THE MOST VULNERABLE TO SUDDEN AND UNEXPECTED DEATH WHETHER BY ACCIDENTAL MEANS OR CHILD ABUSE

Children 0-3, more than any other age group, are more likely to die from unsafe sleep environments, child abuse or accidental injury. OCA prepared this report to promote transparency and accountability of the state's child death review process by providing the public with information related to the preventable deaths of our most vulnerable children.

OCA LOOKED AT ALL UNEXPECTED UNEXPLAINED DEATHS IN 2013 WHERE CHILDREN DID NOT DIE FROM NATURAL CAUSES

OCA reviewed all 82 fatalities of children age birth to three that came to the attention of the Office of the Chief Medical Examiner (OCME) in 2013. OCA's report outlines the findings from these reviews and recommendations to reduce child fatalities through health care reform and child welfare innovation.

- OCA reviewed child specific records, case files, medical examiner reports and pediatric records.
- OCA worked with consultant Dr. Joan Kaufman from Yale University in reviewing the data regarding child death pertinent to this report.
- OCA met with pediatricians to review common issues, strengths and barriers in providing well-child care for at-risk children.
- OCA consulted with various providers who assist in delivering services to at-risk children and their caregivers.
- OCA reviewed DCF Special Review Reports on the deaths of young children.
- OCA conducted an extensive literature review on the topics of child fatality, review, risk, and safety assessment; pediatric best practices, fatality prevention, Sudden Explained Infant Death, early-childhood homicide, child welfare system quality assurance.
- OCA reviewed child death reports across the country, including a recently published report by Casey Family Programs-Florida in 2013 and a report by the Child Welfare League of America, commissioned by Governor Deval Patrick of Massachusetts in 2014.

INFANT TODDLER DEATHS IN 2013: THE NUMBERS

The 82 cases that were reported to OCA from the OCME were 44 natural deaths, 12 accidents, 10 homicides, and 16 undetermined infant and toddler deaths.

Depending on uniformity of definition, there are between 11 and 15 infant-toddler deaths due to maltreatment and/or homicide.

ROLE OF CHILD WELFARE AGENCY AND THE COMMUNITY IN PREVENTING AND RESPONDING TO CHILD ABUSE OR NEGLECT

In Connecticut, DCF is the lead agency for the prevention of child abuse and the protection of children who are victims of abuse or neglect. However, it is vital to underscore that prevention of child maltreatment and child fatalities cannot rest solely with DCF. It will take a collective effort, meaningful and strategic investment in family strengthening and child survival.

To prevent child abuse or neglect from occurring we need to support access to quality child care, effective primary care, supportive home-visiting and other community-based services that raise awareness and offer information and help to caregivers and their children.

We will need to continue to strengthen our investment in an early-child system of care that delivers a continuum of supports to parents and children together, from information and community services to intensive parent-child therapeutic programming. We will need to connect our community programs, including pediatric offices, to this community system of care. Families who need and want support should have ready access to proven, effective, community and home-based supports. These types of supports can be extremely cost-effective for the state and can markedly improve outcomes for children, including reducing incidence of abuse and neglect.

It is important to note that children can die from abuse or neglect without ever coming to the attention of the child welfare agency.

DCF'S PROTECTIVE SERVICE ROLE FOR CHILDREN WHO ARE SUSPECTED OR SUBSTANTIATED VICTIMS OF ABUSE OR NEGLECT

Children that come to DCF's attention are, by definition, high need. They are often young, and are suspected or actual victims of abuse or neglect. DCF responds with guiding families to community assessments and services, or with more rigorous child protective service investigations, case planning, or foster care.

As DCF (as well as other states around the country) moves to increase "family preservation" efforts—removing fewer children into foster care and maintain intact families-- it is essential to look at the quality and outcomes from our work.

It must be said that because a child dies in a home with an open DCF case does not mean that keeping families together, as a goal, is ill fated or undesirable.

As part of OCA's child death review procedure and in keeping with OCA's statutory obligation to oversee and make recommendations regarding state agency practices, the report examined child protective service response to maltreated infants and toddlers who later died from abuse or neglect.

Some of the DCF-involved child deaths reviewed for this report raise questions and sometimes significant concerns regarding the efficacy of agency protocols for ensuring infant safety in high-risk homes.

Not all case records, however, reveal a clear link between a DCF practice issue and a subsequent child fatality, and DCF involvement (or lack thereof) is not always the pivotal factor in each child fatality.

Yet, a *review of all cases provides important information regarding risk factors in families that may contribute to the preventable deaths of children*.

KEY FINDINGS REGARDING FROM 2013 CHILD DEATH REVIEW

Unsafe Sleep and Sudden Infant Death

- Infants in Connecticut were more likely to die from unsafe sleeping conditions than from child abuse, car accidents, choking, drowning, falls, or any other source of accidental injury.

- In 2013, there were approximately 20 infants who died and who were found in unsafe sleep environments.

Accidents a Leading Cause of Death

- Fatality due to accidental causes or injury remains a leading manner of preventable death for infants and toddlers, both in Connecticut and across the nation.

2013 Saw an Unprecedented Rate of Infant-Toddler Homicide

- 2013 saw 10 homicides of children age birth to three, the highest number of reported homicides of young children in Connecticut since OCA and CFRP began collecting data on child deaths over a dozen years ago.

- The majority of alleged perpetrators were men. The majority of children died from child abuse.

Lack of Data Stymies Efforts to Trend and Track Progress

- Connecticut, like the majority of states, struggles to collect and report data regarding preventable infant and toddler deaths, particularly those that are associated with concerns of possible abuse or neglect.

- Many states, including CT, may under-report maltreatment fatalities. This is in part because federal data is typically submitted by the child welfare agency alone, and may not include all relevant child fatalities.

- Federal reports, including a 2011 report from the Government Accountability Office confirms that state data submissions regarding maltreatment fatalities are "only a proportion of all child fatalities caused by abuse or neglect."

- Federal reviewers conclude that there are several factors that complicate states' ability to collect or even compare data from state to state.
  1. Challenges in child death investigation
  2. Over-reliance on CPS reporting
  3. Lack of uniformity regarding assessment, identification and determinations of abuse or neglect.

- The GAO reports that a peer-reviewed study of fatal child maltreatment in three states found that state child welfare records undercount child fatalities from maltreatment by from 55 percent to 76 percent.

- The GAO concludes that a clear picture of the extent of fatalities and near-fatalities of children is essential to understanding the risk factors leading to or associated with maltreatment. Without this data, states will be hampered in developing meaningful prevention strategies. "As a society, we should be doing everything in our collective power to end child deaths and near deaths." GAO Report, July 2011, Conclusion.

PART II of OCA Report: Opportunities to Strengthen DCF Response to High-Risk Infants

Of the 38 non-natural deaths of children in 2013, 21 children lived in families that had current or previous involvement with the Department of Children and Families. 9 of these deaths were associated with abuse or neglect.

Unsafe Sleep/Undetermined Deaths Where Families had Involvement with DCF

- N = 10.

- 7 out of these 10 children had at least one caregiver with a history of recent substance abuse or who admitted to using alcohol or other substances prior to sleeping with the baby.

- 5 of these children were prenatally exposed to substances.

- *The risk of sudden death due to unsafe sleep factors is higher in homes where a parent has untreated mental health issues or is actively substance abusing.*

Homicides, N=5

- 5 children were killed by child abuse. 2 children had cases open with DCF at the time of the fatality. A third child's case was closed the previous year after the infant was diagnosed with injuries consistent with child abuse.

DCF cases reviewed for this report (N=24, inclusive of 3 natural deaths) often did not include a court referral for parental neglect

- Few of the children's cases were referred to juvenile court; none of the children were removed and placed in foster care.

Risk Assessment/Case Planning Gaps

- DCF response to at-risk infants showed gaps in risk assessment, treatment planning, case follow up, and quality assurance.

- Many families had multiple previous contacts with DCF. History ranged from 1 prior report to 14.

- Parents/Caregivers' histories showed frequent histories of trauma, abuse or neglect, substance abuse, mental health challenges and family violence.

- DCF subject-matter specialists were inconsistently utilized in risk assessment or case planning.

- No cases showed application of DCF's current High Risk Newborn policy, even where infants were prenatally drug exposed.

- The key issue in some of the cases is that the intensity of the intervention, focused on treatment and safety, are not always consistent with the degree of risk in the home. It is unclear how the quality of improvement in parental capacity, judgment and decision-making are assessed.

- Case records did not consistently document nature of communication between DCF and local providers or whether providers and DCF had a common understanding of the needs of the family, the goals of the intervention, and how the measure of progress or rehabilitation would be measured.

Need to Increase Use of Evidence-based In-home Clinical Services

- Review of DCF case records often reveals an unmet need for trauma-informed, home-based services for high-need parents and their children.

- Approximately 1/3 of families' records documented referral and engagement with an in-home provider. Home visiting supports did not appear to be routinely offered for young or teenage parents.

DCF Goals Are Moving in a Positive Direction, Need Remains for Robust Review of Quality and Outcomes

- Reports from the Juan F. Federal Court monitor's office for the first quarter of 2014 echo many of the findings contained in OCA's report.

- Monitor's report notes progressive goals at DCF and positive efforts to reduce entry into foster care, eliminate unnecessary reliance on congregate care for children, and increase family-based care for all children. The Monitor notes that DCF is moving in the right direction.

- DCF achieved compliance with 15 out of 22 Outcome Measures, including reunification, adoption, re-entry into custody, training, and visitation in out-of-home cases. Juan. F. Report, 1st Quarter, 2014, pg. 11 (hereinafter Juan F.).

- DCF did not achieve compliance with 7 out of 22 Outcome Measures, including:

    a. Completion of investigations;

    b. Children's needs met;

    c. Worker-child visitation for children still living in-home;

    d. Treatment planning.

- The Monitor's report notes that "deficits in staffing and service resource levels is demonstrated by lowered levels of compliance [with outcome measures], problems with the *quality of investigations services and documentation in the case records*…" Juan F. Report, pg. 5

- Upon review of a sample of 54 cases, the court monitor noted "274 identifiable unmet needs [that] rose to the level of what reviewers felt had a significant negative impact on the health, safety or well-being of the children and families … within the sample." Juan F Report pg. 7.

- Although DCF met its "repeat maltreatment" goal, the Monitor cautioned that verification of compliance with this goal "comes with a caveat" as the Monitor "did uncover issues with the Department's case practice related to Investigations." Juan F. Report, pg. 8.

- According to the monitor's report, "Children at ages two and three, and again at seven and eight appear to have a much higher rate of repeat maltreatment than children of other ages within the sample. Juan F. pg. 23. "Age may be a factor in cases with repeat maltreatment, or at least merits some consideration or weight in planning." Id.

- Reviewers for the federal court monitor wrote numerous comments expressing concern regarding gaps in the quality of early case assessment. Juan F. pp. 31 – 40.

Pediatric Records Often Sparse Regarding Child Welfare or Other Risk Issues

- Pediatric records rarely record awareness of multiple parental risk factors or document the existence or nature of parent counseling or referral.

- Pediatric records do not reflect that social support network, home, or community-based parenting supports are routinely explored.

KEY RECOMMENDATIONS FOR CHILD SURVIVAL

Recommendations emanating from this report fall into two categories:

1. The first category includes things the community and health care systems can do to improve interventions for parents and children and prevent maltreatment before it occurs.

2. The second category are actions that DCF can take to specialize its approach to our most at-risk children: infants and toddlers who are suspected victims of abuse or neglect.

We must know how many children die from accidental causes or maltreatment

- Better develop Connecticut's knowledge and baseline data regarding the number of children who die in unexpected ways, including maltreatment so as to enable the state to track progress with public health reforms and prevention strategies.

Transparency and Accountability for State Investment and Child Survival

- Ensure information about child death reviews, including causes and recommendations for prevention are public, and regularly reviewed so as to inform strategic investment in prevention and treatment strategies.

Invest in Proven and Effective Child Abuse, Child Fatality Prevention Services

- Connecticut is home to several evidence-based parent-child programs that will support better outcomes for children and improve parental functioning, but many programs do not currently have capacity to serve all the parents and children that need them.

- Connecticut must continue to build its continuum of two-generational supports, from home visiting to trauma-informed child-parent psychotherapy. Programs are not one-size fits all, and must be appropriate to level of risk and need in the home.

- Early intervention and treatment is cost-effective; and parents who experience trauma and present with significant mental health and substance abuse issues often need intensive, frequent psychotherapeutic intervention.

- Target home and community-based interventions for fathers and male partners to increase parental judgment and knowledge of child development, essential to reducing the risk of child abuse.

- Ensure all community providers, include in-home service providers are providing counseling regarding safe sleep and shaken baby and documenting problem solving and counseling efforts.

- Collect and report data regarding clinical or other support services that are provided to at-risk parents and young children, with an emphasis on treatment and longitudinal outcomes.

Support Pediatricians' Capacity to Provide Preventative Well-Child Care for young children.

- Ensure that pediatric offices have capacity to offer developmental and mental health screening for children and their caregivers—including maternal depression—and that pediatricians are connected to a continuum of home and community-based resources that will help families.

- Pediatric offices must have access to affordable/reimbursable care coordination not just for children with complex, or chronic disease but for families and children as needed to support a multidisciplinary approach to children's health and well-being.

Increase access to effective substance abuse and domestic violence services for families with very young children.

- Substance abuse and family violence afflicted many families in the case records that OCA reviewed. Ensuring access to high quality services, that can be delivered either in the community or *in the home*, and that includes a relationship, two-generational therapeutic approach, is critical to treating caregivers and protecting children.

Further Innovate Child Welfare's Family Preservation Efforts for Infants and Toddlers.

- Develop a DCF-child welfare practice model specific to children birth to three—include an effective *high risk infant policy*--with appropriate case loads, expert social work and clinical supervision.

- Ensure safe sleeping and other safe parenting strategies are reinforced through frequent monitoring, support from home visitors, and other home-based clinical or medical providers.

- Ensure that all maltreated infants and toddlers that come to the attention of DCF have access to proven parent-child treatments and support services.

- DCF caseload standards must be appropriate to children's needs.

- Case workers must be appropriately credentialed for the intensity and complexity of child welfare practice for families with infants and toddlers.

- Require training for all levels of DCF staff, foster parents, court personnel, relevant service providers, and biological parents about the developmental needs of infants and toddlers and the impact of trauma or maltreatment on infants and toddlers.

- Every DCF office must have access to expertise in early childhood issues; needs of children, heightened risk, developmentally-appropriate case planning.

- Consider a special department within each DCF area office that can work with or plan for families that have very young children (age 0 to 1, or 0 to 2).

- Evaluate and publicly report regarding the value and effectiveness of state-funded child welfare services for abused, neglected and at-risk infants and toddlers, with attention to outcomes, disaggregated by age.